

## **Clinical Policy: Factor VIIa, Recombinant (NovoSeven RT)**

Reference Number: CP.PHAR.220

Effective Date: 05.01.16

Last Review Date: 02.19

Line of Business: Medicaid, HIM-Medical Benefit

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Factor VIIa, recombinant (NovoSeven<sup>®</sup> RT) is a coagulation factor.

### **FDA Approved Indication(s)**

NovoSeven RT is indicated for treatment of bleeding episodes and perioperative management in:

- Adults and children with hemophilia A or B with inhibitors, congenital FVII deficiency, and Glanzmann's thrombasthenia with refractoriness to platelet transfusions, with or without antibodies to platelets
- Adults with acquired hemophilia

### **Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that NovoSeven RT is a **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Hemophilia A or B with Inhibitors, Congenital Factor VII Deficiency** (must meet all):

1. Diagnosis of one of the following (a or b):
  - a. Congenital or acquired hemophilia A or B with inhibitors;
  - b. Congenital factor VII deficiency;
2. Prescribed by or in consultation with a hematologist;
3. Request is for one of the following uses (a or b):
  - a. Control and prevention of bleeding episodes;
  - b. Perioperative management;
4. Dose does not exceed one of the following (a or b):
  - a. Hemophilia: 90 mcg/kg every two hours;
  - b. Congenital factor VII deficiency: 30 mcg/kg every four hours.

**Approval duration: 3 months**

##### **B. Glanzmann's Thrombasthenia** (must meet all):

1. Diagnosis of Glanzmann's thrombasthenia;
2. Prescribed by or in consultation with a hematologist;
3. Condition is refractory to platelet transfusions;
4. Request is for one of the following uses (a or b):

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- a. Control and prevention of bleeding episodes;
- b. Perioperative management;
5. Dose does not exceed 90 mcg/kg every two hours.

**Approval duration: 3 months**

**C. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and HIM-Medical Benefit.

**II. Continued Therapy****A. All Indications in Section I (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed one of the following (a or b):
  - a. Congenital factor VII deficiency: 30 mcg/kg every four hours;
  - b. All other indications: 90 mcg/kg every two hours.

**Approval duration: 3 months**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.  
**Approval duration: Duration of request or 3 months (whichever is less);** or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and HIM-Medical Benefit.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 for Medicaid and HIM-Medical Benefit or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

*Appendix B: Therapeutic Alternatives*

Not applicable

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): none reported
- Boxed warning(s): thrombosis

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*Appendix D: General Information*

- Congenital hemophilia A is a deficiency of factor VIII.
- Congenital hemophilia B is a deficiency of factor IX.
- Acquired hemophilia is evidenced by presence of coagulation factor inhibitors (autoantibodies).

**V. Dosage and Administration**

<b>Indication</b>	<b>Dosing Regimen</b>	<b>Maximum Dose</b>
Treatment of bleeding episodes	<p><u>Congenital hemophilia A or B with inhibitors:</u></p> <ul style="list-style-type: none"> <li>• 90 mcg/kg IV every 2 hours, adjustable based on severity of bleeding until hemostasis is achieved</li> <li>• 90 mcg/kg IV every 3-6 hours after hemostasis is achieved for severe bleeds</li> </ul> <p><u>Congenital factor VII deficiency:</u> 15-30 mcg/kg IV every 4-6 hours until hemostasis is achieved</p> <p><u>Glanzmann’s thrombasthenia:</u> 90 mcg/kg IV every 2-6 hours until hemostasis is achieved</p> <p><u>Acquired hemophilia:</u> 70-90 mcg/kg IV every 2-3 hours until hemostasis is achieved</p>	<p>Congenital factor VII deficiency: 30 mcg/kg every 4 hours</p> <p>All other indications: 90 mcg/kg every 2 hours</p>
Peri-operative management	<p><u>Congenital hemophilia A or B with inhibitors:</u></p> <p><i>Minor surgery:</i></p> <ul style="list-style-type: none"> <li>• 90 mcg/kg IV immediately before surgery, repeat every 2 hours during surgery</li> <li>• 90 mcg/kg IV every 2 hours after surgery for 48 hours, then every 2-6 hours until healing has occurred</li> </ul> <p><i>Major surgery:</i></p> <ul style="list-style-type: none"> <li>• 90 mcg/kg IV immediately before surgery, repeat every 2 hours during surgery</li> <li>• 90 mcg/kg IV every 2 hours after surgery for 5 days, then every 4 hours or by continuous infusion at 50 mcg/kg/hour until healing has occurred</li> <li>• Additional boluses can be given</li> </ul> <p><u>Congenital factor VII deficiency:</u></p>	<p>Congenital factor VII deficiency: 30 mcg/kg every 4 hours</p> <p>Glanzmann’s thrombasthenia: 140 mcg/kg every 2 hours</p> <p>All other indications: 90 mcg/kg every 2 hours</p>

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Indication	Dosing Regimen	Maximum Dose
	<p>15-30 mcg/kg IV immediately before surgery and every 4-6 hours for the duration of surgery and until hemostasis is achieved Note: doses as low as 10 mcg/kg can be effective</p> <p><u>Glanzmann’s thrombasthenia:</u></p> <ul style="list-style-type: none"> <li>• 90 mcg/kg IV immediately before surgery and repeat every 2 hours for the duration of the procedure</li> <li>• 90 mcg/kg IV every 2-6 hours to prevent postoperative bleeding</li> <li>• Higher doses of 100-140 mcg/kg can be used for surgical patients who have clinical refractoriness with or without platelet-specific antibodies</li> </ul> <p><u>Acquired hemophilia:</u> 70-90 mcg/kg immediately before surgery and every 2-3 hours for the duration of surgery and until hemostasis is achieved</p>	

**VI. Product Availability**

Powder for reconstitution in single-use vial: 1, 2, 5, 8 mg

**VII. References**

1. NovoSeven RT Prescribing Information. Plainsboro, NJ: Novo Nordisk, Inc.; October 2018. Available at <http://www.novosevenrt.com>. Accessed November 8, 2018.
2. Srivastava A, Brewer AK, Mauser-Bunschoten EP, et al. Guidelines for the management of hemophilia. Haemophilia. Jan 2013; 19(1): e1-47.
3. Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation (NHF): Database of treatment guidelines. Available at <https://www.hemophilia.org/Researchers-Healthcare-Providers/Medical-and-Scientific-Advisory-Council-MASAC/MASAC-Recommendations>. Accessed September 26, 2018.

**Coding Implications**

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J7189	Factor VIIa (antihemophilic factor, recombinant), per 1 mcg

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.12.Blood Factors and converted to new template. Removed specific titer levels and factor VIII dose increases. Approval period for non-prophylactic use is edited to provide 3 months on initial approval and one 3-month re-auth. Added criteria for Glanzmann’s thrombasthenia. Reviewed by specialist.	04.01.16	05.16
Safety information removed. Wording for uses and approval periods for all blood factor products made consistent across all policies. Efficacy statement added to renewal criteria. Hemophilias are specified as “congenital” versus “acquired” across blood factor policies where indicated. Added requirement that acquired hemophilia be evidenced by the presence of factor VIII inhibitors. Reviewed by specialist- hematology/internal medicine.	04.01.17	05.17
1Q18 annual review: - No significant changes - Converted to new template - References reviewed and updated.	11.29.17	02.18
1Q 2019 annual review: added HIM-Medical Benefit; no significant changes; references reviewed and updated.	09.26.18	02.19

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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